**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor Name and Address:<br>TGZ ACQUISITION CO LLC DBA JACE SYSTEMS<br>2 PIN OAK LANE SUITE 200<br>CHERRY HILL NJ 08003 | MFDR Tracking #: M4-05-3071-01 |
| | DWC Claim #: |
| | Injured Employee: |
| Respondent Name and Box #:<br>TEXAS MUTUAL INSURANCE CO<br>Box #: 54 | Date of Injury: |
| | Employer Name: |
| | Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "We billed our UCR of $75.00 per day; the carrier paid $28.41 per day. Knee CPM Medicare allowable for Texas $22.73. $22.73 X 1.25 = $28.41." "Texas Worker's Compensation Insurance Fund, prior to 2003 reimbursement for the CPM Hand and all upper extremities was $45.00." "Please consider the above information and approve reimbursement at the lessor of $45.00 per day. Allowing for additional payment of $514.29."

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought $514.29

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "Reimbursement based on the Palmetto GBA[2], DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, Supplies)[3] fee schedule is $28.41 a day for code E0935." "It is this carrier's position that the Medicare reimbursement for code E0935 is NOT limited to the knee and that it is reasonable to reimburse $75 for CPM of the hand and $28.41 for the knee." "The American Medical Association's HCPCS code E0935 is NOT limited to a given body area." "The requester is confusing Medicare Coverage with the Medicare Durable Medical Equipment Region C Fee Schedule. There is no reason to believe the reimbursement rate enumerated for code E0935 is NOT the reimbursement rate for CPM of the hand. That Medicare felt the need to enumerate a coverage policy limiting reimbursement to the knee further supports that the code E0935 and the reimbursement rate associated with that code, is not limited to the knee."

**Principal Documentation:**

1. Response Package

## PART IV: SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Calculations | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 12/11/2003 through 01/10/2004 | E0935 (X30) | 22.73 X 125% = $28.41 X 14 = $397.74. This amount minus previously paid of $397.74 = $0.00. | $514.29 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. This request for medical fee dispute resolution was received by the Division on December 27, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 31, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.

3. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 1/27/ 2004, 1/28/2004, 2/2/2004, 2/4/2004

   - F, 01-The charge for the procedure exceeds the amount indicted in the fee schedule.

   Explanation of benefits dated 4/14/2004

   - M, RD-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B).

   Explanation of benefits dated 8/11/2004

   - RD-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B).
   - YD-Duplicate appeal. An appeal of the original audit decision was previously performed for these services. If you disagree with the original appeal decision, you may request medical dispute resolution through the Texas Workers' Compensation Commission.

   Explanation of benefits dated 8/13/2004

   - RD-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B).
   - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.

   Explanation of benefits dated 8/31/2004

   - D, 60-The provider has billed for the exact services on a previous bill.

**Issues**

1. Was the dispute filed in the form and manner prescribed under Division rules at 28 TAC §133.307?
2. Is the respondent's denial supported?
3. What is the applicable rule for reimbursement?
4. Is the requestor entitled to additional reimbursement

**Findings**

1. Division rule at 28 TAC §133.307(d)(1) requires that "A request for medical dispute resolution…shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute." The Division received the request for medical fee dispute resolution on December 27, 2004. Therefore, disputed dates of service December 11, 2003 through December 23, 2003 were not submitted timely in accordance with Division rule at 28 TAC §133.307(d)(1), and will not be considered further in this decision.
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

- HCPCS code E0935 is described as “Continuous passive motion exercise device.” Per DMEPOS, HCPCS code E0935 has a fee of $22.73.

4. Reimbursement will therefore be calculated according to Division rule at 28 TAC §134.202(c)(2), for HCPCS codes E0935.

   - Per DMEPOS, HCPCS code E0935 has a MAR of $22.73. The requestor billed for 30 units; however, only 14 units are eligible for review (12/27/2003 through 1/10/2004). $22.73 X 125% = $28.41 X 14 = $397.74. This amount minus previously paid of $397.74 = $0.00.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor for HCPCS code E0935. For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

**PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

| Authorized Signature | Medical Fee Dispute Resolution Officer | **July 6, 2010** |
|---|---|---|
| | | Date |

**PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**